

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

04280

## CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH: *Wilcombs*  
County *Salisbury*  
City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
*P.O. Hight*  
How long in hospital or institution? *6 hrs. 40 min.*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For new-born infants give residence of mother)  
State *MD.* County *Wilcombs*  
City or town *Salisbury*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *201 E. Lockhart St.*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *Hermie L. Adkins*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widower*

6. (b) Name of husband or wife *Marjorie Adkins*

7. Birth date of deceased (mo., day, yr.) *July 12-1892* 6. (c) If alive, give age *Dead* years

8. AGE: Years *55* Months *9* Days *9* If less than one day hrs. min.

9. Birthplace *P.O. Pocomoke Md.*  
(Town, county, and state)

10. Usual occupation *Letter*

11. Industry or business

12. Name *John A. Adkins*

13. Birthplace *Wilcombs Co. Md.*

14. Maiden name *Charlotte Jane Davis*

15. Birthplace *Wilcombs Co. Md.*

16. Informant *Mrs. Annie M. Finnet (Wife)*

Address *315 E. Vine St. Salisbury Md.*

17. Burial *Buried* Date thereof *April 12-48*  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery *Bethel Church Cem.*

Location *Wilcombs Md.*

18. Funeral director *Hillman & Co. Walter R. Hillman*

Address *Salisbury Md.*

19. *4/24/48* 19 *48* *Barriett J. Johnson*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *April 21st 1948* at *3 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Medical Examiner's Certificate*  
and that I last saw him alive on *19*

Immediate cause of death *Crushing Injury of Chest*  
(Autopsy or Necropsy) *(Autopsy or Necropsy)*

Due to *Struck by Automobile*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *Accident* Date of *4/20/48*

Accident, suicide, or homicide *Salisbury Wilcombs Maryland*  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Highway*

Means of injury *Struck by Automobile* Injured at work? *No*

23. SIGNATURE *Charles H. Finnet* Deputy Medical Examiner M. D. or other

Address *Salisbury Maryland* Date signed *4/21/48*

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... Wicomico  
 City or town... Salmon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... life  
 Hospital, institution, or street address where death occurred:  
 Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County... Wicomico  
 City or town... Salmon  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Elsie Mae Carmish Birchhead

## 3. (b) Social Security Number

4. Sex F 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife... Loney Birchhead  
 6. (c) If alive, give age 48 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 28, 1907  
 8. AGE: Years 41 Months 2 Days 27 If less than one day  
 hrs. min.

9. Birthplace... Hebron, Wicomico, Md.  
 (Town, county, and state)

10. Usual occupation... housewife

11. Industry or business

12. Name... Wesley Carmish  
 13. Birthplace... Salmon, Md.

14. Maiden name... Josephine Massis

15. Birthplace... Hebron, Md.

16. Informant... Josephine Carmish  
 Address... Hebron, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 4/27/48  
 (month) (day) (year)

Cemetery or crematory... Rockwood Cemetery

Location... Rockwood, Md.

18. Funeral director... Daniel K. Murrell

Address... Hebron, Md.

19. Date received by registrar... 4/27/48 Registrar... Wesley Carmish

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 4/24/48 19... 48 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 19... 48 to April 23rd 19... 48  
 and that I last saw him alive on April 23rd 19... 48

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... William E. Smith M. D. or other

Address... Hebron, Md. Date signed... April 26-48

STATE OF NEW YORK

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

MAY 15 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1228

04282

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 27 hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WicomicoCity or town... Fruitland  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

GRACE E. BLACK

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Walter Black

7. Birth date of deceased (mo., day, yr.)

Dec. 27, 1916

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

32 yrs

..... hrs. .... min.

9. Birthplace

Quantico, Md.  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

none

FATHER

12. Name

Charles E. Gray

13. Birthplace

Quantico

MOTHER

14. Maiden name

Mary M. Wilson

15. Birthplace

Head Creek, Md.

16. Informant

Walter Black

Address

Fruitland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

April 13, 1948  
(month) (day) (year)

Cemetery or crematory

Fruitland Cem.

Location

Fruitland, Md.

18. Funeral director

Address

Booker M. West  
Salisbury, Md.

19.

(Date rec'd by registrar)

4/13/48Harriet L. JohnsonRegistrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 11 19... 48 at 12:03 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 21, 1948 to April 11 19... 48and that I last saw him alive on April 10 19... 48

Immediate cause of death

Intestinal obstruction

Due to

Perforation of terminal

Due to

adhesions

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Jejunum slum

Autopsy results

Jejunum perforated Date of op. April 10, 1948

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harriet L. Johnson M.D. or other  
Address Salisbury, Md. Date signed 4-11-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

**RECEIVED**

MAY 14 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04283 335

## 1. PLACE OF DEATH:

County WicomicoCity or town Sharptown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 41

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicCity or town Sharptown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Fredrick S. Bounds

## 3. (b) Social Security Number

216-07-50164. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Linnie Bounds7. Birth date of deceased (mo., day, yr.) Sept 7 1872 6. (c) If alive, give age 71 years8. AGE: Years 75 Months 7 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Quantico Nic Md  
(Town, county, and state)10. Usual occupation Retired Foreman of  
bucket factory

11. Industry or business

12. Name James R. Bounds13. Birthplace Md14. Maiden name Elizabeth Phillips15. Birthplace Del.16. Informant Linnie BoundsAddress Sharptown Md.17. Burial Date thereof 4.24.1948  
(Burial, cremation, or removal of body)Cemetery or crematory FuemanLocation Sharptown18. Funeral director Gravener BoosAddress Sharptown Md19. 4-24 19 48 Walter G. Mann  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-21-1948 at 3 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to April 1948and that I last saw him alive on April 20 1948Immediate cause of death myocarditis DURATION 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James Phillips - M.D. M. D. or otherAddress Laurel, Del Date signed 4-22-48



RECEIVED

APR 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 JUN -8 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County Wicomico

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12

Hospital, institution, or street address where death occurred:

303 William St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico

City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 E. William St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

John M. Bradley

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Abbie C. Bradley

7. Birth date of deceased (mo., day, yr.) 1887 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 91 Months 90 Days 10 6 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland, MD  
(Town, county, and state)

10. Usual occupation Foundry Worker

11. Industry or business Intermittent

12. Name John M. Bradley

13. Birthplace Unknown

14. Maiden name Mary Bennett

15. Birthplace Unknown

16. Informant Mrs. Nancy H. Noyman

Address 303 E. William St

17. Buried Date thereof 4/23/48  
(Burial, cremation, or removal, AV, etc.) (month) (day) (year)

Cemetery or crematory W. Williams

Location St. Johns, Delaware

18. Funeral director The Bell Funeral Co.

Address Salisbury, MD

19. 4/23/48 19 48 Registrar Barriest E. Johnson  
(Date recorded by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 48 at 5:22 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 19 48 to April 21 19 48

and that I last saw him alive on April 20 19 48

Immediate cause of death ?

Due to Arteriosclerotic C-V-R

Due to Dissecting

Other conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

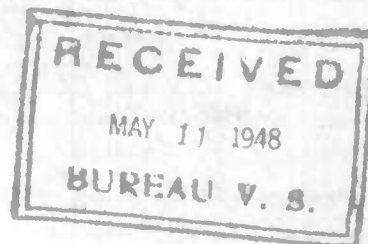
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. Gray, MD

Address Salisbury, MD Date signed 4/23/48



Dr. Long-Brick

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

128

04285

## CERTIFICATE OF DEATH

Reg. Dist. No. 335

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 8 days - 14 hrs. 50 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Eden  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Byrd, Mrs. Virginia Byrd

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (g) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mr. William Byrd7. Birth date of deceased (mo., day, yr.) August 15, 19226. (c) If alive, give age 33 years

8. AGE:

Years

Months

Days

If less than one day

25526

hrs.

min.

9. Birthplace Princess Anne - Somerset, Md  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Emerson Byrd13. Birthplace Somerset Co., Md14. Maiden name Larsine Noel15. Birthplace Unknown16. Informant William N. ByrdAddress Rt 1 Eden, Md17. Byrd Date thereof Apr 14, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Asbury CemeteryLocation Asbury, Chaptin, Md18. Funeral director Carlson LawtonAddress Chaptin, Md19. 4/13, 1948 Registrar Edna O. Johnson

(Date registered by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 48 at 10:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4.3.48 19 48 to 4.11 19 48and that I last saw her alive on 4.11.48 19 48

Immediate cause of death

Acute Hemorrhagic Pancreatitis

DURATION

8 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Fat necrosis - bile like peritoneal effusion Date of op. 4.3.48Autopsy results Postperitoneal necrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Edna O. Johnson M. D. or other 2609

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04286

Reg. Dist. No. 338

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Gen. Hosp.  
 How long in hospital or institution? 12 da 8 hr. 20 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State MD County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 110 Pinchum Ave.  
 (If rural, give LOCATION)

(g) If veteran, name war

## 3. (a) FULL NAME

Grannell B. Cantrell

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Minnie Cantrell

7. Birth date of

deceased (mo., day, yr.)

Oct. 12-1886

6. (c) If alive, give age

60 years

8. AGE:

Years

61

Months

6

Days

11

If less than one day

hrs. min.

9. Birthplace

Allen Maryland

(Town, county, and state)

10. Usual occupation

Nurse

11. Industry or business

N.F. Allen & Co.

MOTHER

FATHER

12. Name

Samuel Cantrell

13. Birthplace

Allen Maryland

14. Maiden name

Sallie Melma

15. Birthplace

Allen Maryland

16. Informant

Mr. Minnie Cantrell

Address

110 W. Pinchum Ave. Salisbury Md

17. Burial, cremation, or removal. Which?

Buried

Date thereof

April 25-1948

Cemetery or crematory

Wes. Mem. Park

Location

Hollingsworth & Walter R. Hollingsworth

18. Funeral director

Salisbury Md

19.

(Date read by registrar)

4/10/48Barbara B. JohnsonSalisbury Md

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 23rd 1948 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/11 1948 to 4/23 1948and that I last saw him alive on 4/23 1948

Immediate cause of death

Pulmonary Embolism

DURATION

SuddenDue to Labor Pulmonary17 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver G. Fisher MD

M. D. or other

Address Salisbury MdDate signed 4/24/48

RECEIVED

MAY 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

04287

## 1. PLACE OF DEATH

County McComieCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1129 N. Main St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComieCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1129 N. Main Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Beatrude Carter

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Stephen A. Carter6. (c) If alive, give age 74 years

7. Birth date of

deceased (mo., day, yr.)

April 6 - 1883

8. AGE:

Years

Months

Days

If less than one day

6556

hrs.

min.

9. Birthplace

Connet Co. Md.  
(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

FATHER

12. Name

John N. Powell

13. Birthplace

Connet Co. Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

M. Stephen A. Carter

16. Informant

Address

1129 N. Main St. Salisbury Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date there

(month) (day) (year)

Cemetery

Friendship Ln

Location

P.O. Puncture Plume Md

18. Funeral director

Address

Hollings & G. Walter H. Hollings

Address

Salisbury Md.

19. Date

(Date rec'd by registrar)

19. 48

48

48

48

48

48

48

48

48

48

48

48

48

48

48

48

48

48

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb1948toApril 12 1948

and that I last saw her alive on

April 101948

Immediate cause of death

Respiratory failure

DURATION

Due to

Carcinoma of breast 2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert R. Starr

M. D. or other

Address

Salisbury

Date signed

4-12-48



RECEIVED

APR 24 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Wicomico  
City or town Quantico P.O. #1  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 18 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Wicomico  
City or town Quantico  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. P.O. #1  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Margaret Anna Cooper

### 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Orlando Cortez Cooper  
6. (c) If alive, give age 85 years  
7. Birth date of deceased (mo., day, yr.) Dec 4, 1868  
8. AGE: Years 79 Months 4 Days 12 If less than one day  
hrs. min.

9. Birthplace Green Hill Md. Wicomico  
(Town, county, and state)

10. Usual occupation House work

11. Industry or business at home

12. Name Samuel Hopkins

13. Birthplace Green Hill Md. Wicomico

14. Maiden name Henneta Hearn

15. Birthplace Green Hill Md. Wicomico

16. Informant Fred L. Cooper

Address Quantico Md. Route #1

17. Burial Date thereof April 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wicomico Memorial Park

Location Salisbury Maryland.

18. Funeral director Hollman & Co. Salisbury Md.

Address Salisbury Maryland.

19. 4/18 19 48 Harriet L. Johnson  
(Date rec'd by registry) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 48 at 1:40 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from 15 March 19 48 to 16 April 19 48

and that I last saw he alive on 16 April 19 48

Immediate cause of death Cerebral Thrombosis

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Donald H. Sanders  
M. D. or other

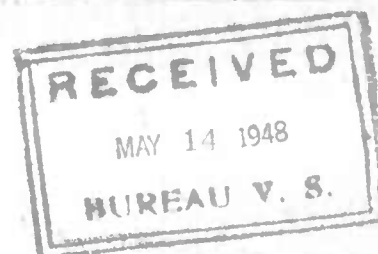
Address Quantico Md. Date signed 17 April 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 83a 04289 933

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)  
 State MD County Wicomico  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

William Jordan Parby

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Sarah E. Parby7. Birth date of deceased (mo., day, yr.) July 12, 1870 8. (c) If alive, give age, years8. AGE: Years 77 Months 9 Days 10 If less than one day hrs. min.9. Birthplace Wicomico, Md. (Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name William Parby13. Birthplace Wicomico, Md.14. Maiden name Mrs. Sarah E. Parby15. Birthplace Wicomico, Md.16. Informant Mrs. Sarah E. ParbyAddress Quantico, Md.17. Burial Date thereof 4/22/48  
 (Burial, cremation, or reinterment) (month) (day) (year)Cemetery or crematory Quantico, Md.Location Quantico, Md.18. Funeral director David F. MessingAddress Hebron, Md.19. 4/28/48 48 Barrett E. Johnson  
 (Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/22/48 19 48 at 6:45 M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 19 48 to April 20th 19 48 and that I last saw him alive on April 20th 19 48Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Smith M. D. co-authorAddress Hebron, Md. Date signed April 22-48

RECEIVED

MAY 11 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131w

04290

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date filed by registrar)

19. 48.

Registrar

Address

23. SIGNATURE

M. D. or other

Address

Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-5-

19. 47.

to

4-14

19. 48.

and that I last saw him alive on

4-14

19. 48.

Immediate cause of death

DURATION

Cardio-vascular renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

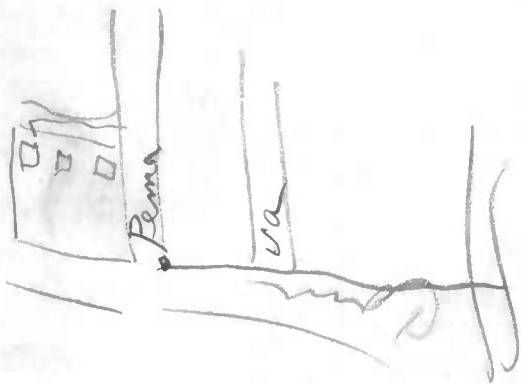
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

102 Federal St  
Myo Davis



RECEIVED  
APR 24 1948  
BUREAU V. S.

Myo Davis



Dr. Gimmse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

04291

CERTIFICATE OF DEATH

Reg. Dist. No. 935

1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 Days  
Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 210 Broad Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war 70

3. (a) FULL NAME

Davis, Mr. William

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced MARRIED  
6. (b) Name of husband or wife Mrs Margaret Davis  
6. (c) If alive, give age 45 years  
7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1899  
8. AGE: Years 45 Months 3 Days 3 If less than one day hrs. min.

9. Birthplace Pittsboro, Wicomico, Md  
(Town, county, and state)

10. Usual occupation Seaman, Distillery

11. Industry or business

12. Name Seamus W. Davis

13. Birthplace Maryland

14. Maiden name Effie K. Humphreys

15. Birthplace Maryland

16. Informant Mrs. Katherine Bertali

Address 210 Broad St. Salisbury, Md

17. Burial (Burial, cremation, or removal, which?) Whale Methodist Date thereof April 13/48 (month) (day) (year)

Cemetery or crematory Whale Methodist

Location Whale Methodist, Md

18. Funeral director W. O. Thomas

Address Snow Hill, Md

19. 4/14/48 19 48 Registrar Dr. Gimmse

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13<sup>th</sup> 19 48 at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 48 to 4/13 19 48 and that I last saw him alive on 4/12 19 48

Immediate cause of death Pulmonary Tbc.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fred R. Gimmse M.D. M. D. or other

Address Salisbury, Md Date signed 4/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

5091

RECEIVED

APR 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04292333

## 1. PLACE OF DEATH:

County WicomicoCity or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town Delmar Berlin P.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Purnell Joshua Dennis.

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married6.(b) Name of husband or wife Oralanta Dennis7. Birth date of deceased (mo., day, yr.) Sept. 25, 1873  
6.(c) If alive, give age 72 years8. AGE: Years Months Days If less than one day  
74 6 16 hrs. min.9. Birthplace Berlin Wic Co. Md. R.D.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John Dennis.13. Birthplace md.14. Maiden name Sally Martha Jarman15. Birthplace md.16. Informant Mr. Bassett DennisAddress Delmar md.17. Burial Date thereof 4/14/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory BuckinghamLocation Berlin md.18. Funeral director Anna B. BurbageAddress Berlin md.19. 4/14/48 md. assault by John  
(Date rec'd by registrar) (Place) (Cause)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1948 at 6:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1948 to April 11 1948and that I last saw him alive on April 11 1948Immediate cause of death Internal oblation DURATIONDue to coronary artery diseaseDue to of color.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.H. Lynch M. D. or otherAddress Delmar md. Date signed Apr. 12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **532**

### 1. PLACE OF DEATH:

County Wicomico  
City or town Allen Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? no

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Wicomico  
City or town Allen Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. no  
(If rural, give LOCATION) no  
2. (a) If veteran, name war no

### 3. (a) FULL NAME

William Dennis  
4. Sex male 5. Color or race aa 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Elizabeth Dennis  
7. Birth date of deceased (mo., day, year) yes 6. (c) If alive, give age not known years  
8. AGE: Years 100 Months 13 Days 1848  
If less than one day  
hrs. min.

### 3. (b) Social Security Number

no

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4-24 19 48 at 7:15 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical certificate and that I last saw him alive on 4/24/48 19 48  
Immediate cause of death coronary occlusion  
DURATION suffered  
Due to no  
Due to no  
Other conditions no  
(Include pregnancy within 3 months of death)  
Major findings of operations no  
Autopsy results no  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Allen Md  
(Town, county, and state)  
10. Usual occupation wood planning  
11. Industry or business Same as above  
FATHER 12. Name Arroy Dennis  
13. Birthplace Allen Md  
MOTHER 14. Maiden name Paulie Dennis  
15. Birthplace Frederick Md  
16. Informant Herman Dennis  
Address Salisbury Md  
17. Burial Date thereof Apr 27, 1948  
(Burial, cremation, or other) (month) (day) (year)  
Cemetery or crematorium Friendship  
Location Allen Md  
18. Funeral director James H. Stewart  
Address Salisbury Md

19. 4/27 19 48 Registrar James H. Stewart  
(Date rec'd by registrar)

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide no Date of no  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE SA Padaniger MD  
Deputy Med Exam.  
M. D. or other  
Address Salisbury Md Date signed 4/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 15 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 373

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrsHospital, institution, or street address where death occurred:  
306 Hastings St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 306 Hastings St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Fred Irvin Dryden

## 3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Alta Elizabeth Dryden7. Birth date of deceased (mo., day, yr.) Sept 22, 1896

6. (c) If alive, give age years

8. AGE: Years 51 Months 6 Days 22 It less than one day9. Birthplace Whitesburg, Worcester, Md  
(City, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name James Dryden13. Birthplace Whitesburg, Md14. Maiden name Elizabeth15. Birthplace Princess Anne, Md16. Informant Alta Elizabeth DrydenAddress 306 Hastings St17. Burial Date thereof April 18 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory OliverLocation Snow Hill Md18. Funeral director The Hill & Graham CoAddress Salisbury Md19. 4/18/48 19 48 Barralet J. J. Registrar  
(Date recorded by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-15 19 48 at 1130 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47 to 4-15 19 48and that I last saw him alive on 4-15 19 48Immediate cause of death Starvationself imposedDURATION 3 yrsDue to Psychoses

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Rule

M. D. or other

Address 306 Hastings St Date signed 4-17-48

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. **Correct age** is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

04295

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 218 E Isabelle ST  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Duke Mr. Lauder DUKES

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Duke Mrs. Ella

## 7. Birth date of deceased (mo., day, yr.)

April 21, 1885

## 6. (c) If alive, give age

63 years

## 8. AGE:

63 Years0 Months2 Days

If less than one day

hrs.min.

## 9. Birthplace

Gumbard, Delaware  
(Town, county and state)

## 10. Usual occupation

Contractor

## 11. Industry or business

MOTHER FATHER

## 12. Name

William F. Dupuy

## 13. Birthplace

Gumbard, Delaware

## 14. Maiden name

Grace Mitchell

## 15. Birthplace

Salisbury, Md

## 16. Informant

Mrs. Ella Dukes

## Address

Salisbury, Md

## 17.

(Burial, cremation, or removal, which?)

Date thereof

4/25/48  
(month) (day) (year)

## Cemetery or crematory

Grace

## Location

Salisbury, Md

## 18. Funeral director

The Hall & Johnson Co

## Address

Salisbury, Md

## 19.

(Date of death by registrar)

19. 4/24

## 23. SIGNATURE

[Signature]

M. D. or other

Address [Signature] Date signed 4/15/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/23 19 48 at 8:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 48to 4/2319. 48and that I last saw him alive on 4/23 19. 48

Immediate cause of death

Myocardial Infarction  
Heart Disease, Fatigue

## DURATION

WeeksWeek

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Myocardial InfarctionDate of op. 4/20/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

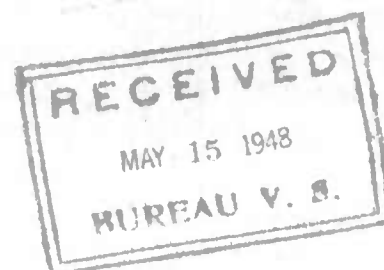
Injured at work?

## 23. SIGNATURE

[Signature]

M. D. or other

Address [Signature] Date signed 4/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
P.R.R. Tracks

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street R.D. near Silver Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Everle - Frances F.

## 3.(b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Fred or Frederick J. Everle6.(c) If alive, give age 61 years

## 7. Birth date of deceased (mo., day, year)

April 6 - 1889

## 8. AGE:

Years 59 Months 0 Days 19 If less than one day hrs. min.

## 9. Birthplace

Brooklyn N.Y.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

at home

## 12. Name

Brooklyn N.Y.

## 13. Birthplace

no. Recd.

## 14. Maiden name

no. Recd.

## 15. Birthplace

no. Recd.

## 16. Informant

Mr. Evelyn Brandish (Brandish)

## Address

107 Elm St. Kingston Conn.

## 17. Burial

April 28 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

## Cemetery or crematory

Wicomico Memorial Park

## Location

Salisbury Maryland

## 18. Funeral director

Holloway & G. Walter R. Holloway

## Address

Salisbury Md.

## 19. Date rec'd by registrar

4/28/48 1948 Registrar W. H. Barrett

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-25 1948 at 3:43 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

immediately 1948 to immediately 1948and that I last saw immediately alive on 4-25-48 1948

Immediate cause of death

Compound Fractured SkullFracture of SkullFractured R. Humerus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidentWhere did injury occur? Salisbury Wicomico (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Salisbury & R. PerryMeans of injury Truck struck injured at work? no23. SIGNATURE W. H. Barrett M. D. or otherAddress Salisbury Md.Date signed 4/28/48

## DURATION

Suddendeath

RECEIVED

MAY 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

## CERTIFICATE OF DEATH

Reg. Dist. No. 338

04297

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred  
Seloom, Md  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8 miles south of Salisbury  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Louis Fuchs  
 Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife NONE  
 7. Birth date of deceased (mo., day, yr.) Jan 16, 1895  
 6.(c) If alive, give age ✓ years

8. AGE: Years 73 Months 2 Days 16 If less than one day  
 hrs. min.

9. Birthplace Brooklyn, N.Y.  
 (Town, county, and state)

10. Usual occupation Railroader

11. Industry or business

12. Name Louis Fuchs

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Germany

16. Informant Mrs John Schrimber

Address Buffalo, N.Y.

17. Burial Date thereof April 11, 1948  
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Seloom

Location Seloom, Md

18. Funeral director The Bell & Johnson Co

Address Salisbury, Md

19. 4/18/48 Registrar Barrett

(Date rec'd by registrar) 19 48 Registrar Barrett

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12, 1948 to April 8, 1948  
 and that I last saw him alive on April 8, 1948

Immediate cause of death Congestive Heart Failure DURATION

Due to Myocarditis ?

Due to Chronic Valvular Disease ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John H. Yeaman MD. M. D. or other

Address 238 Linden Ave. Date signed April 8, 1948





PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 433

## 1. PLACE OF DEATH:

County Micomic  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 hours  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 24 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico  
 City or town Quantico  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Baby girl Gale

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Premature Baby

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 4-10-48 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day 24 hrs. \_\_\_\_\_ min.

9. Birthplace Salisbury, Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Deane Handy Gale13. Birthplace Quantico14. Maiden name Ruth Lela Austin15. Birthplace Quantico16. Informant FatherAddress Quantico Md.

17. Cremation Date thereof 4/12/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Peninsula General HospitalLocation Salisbury, Md.18. Funeral director Peninsula General HospitalAddress Salisbury, Md.

19. 4/12 19 48 Harriet L. Johnson  
 (Date rec'd by Registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 48 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Prematurely 6 1/2 mos.Due to Natural Causes

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Deane Handy Gale

M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 12 April 48



RECEIVED

APR 24 1948

BUREAU V. S.

Evidence for change of  
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04299

FILE NO. G 115 APR 26 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH:

County Wicomico md  
City or town Pontilake md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3.4 years  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED;  
(For newborn infants give residence of mother)

State MD County Wicomico  
City or town Pontilake md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. no  
(If rural, give LOCATION) no  
2.(a) If veteran, name war no

3. (a) FULL NAME

Blasie Hardy

3. (b) Social Security Number

4-215-05-3316

4. Sex Female 5. Color or race a a 6. (a) Single, married, widowed, or divorced married

(b) Name of husband or wife Albert Hardy  
yes 6. (c) If alive, give age don't know years

7. Birth date of deceased (mo., day, yr.) 1899 1898

8. AGE: Years 50 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Plained Quarter md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Wm. Fields

13. Birthplace James Quarter

14. Maiden name Sarah Jones

15. Birthplace James Quarter md

16. Informant Albert Hardy

Address Pontilake md

17. Burial Date thereof Apr 8 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pontilake

Location Pontilake md

18. Funeral director James Stewart

Address Sahabury md

19. 4/8 19. 48 Registrar Richard W. Saunders

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 April 19. 48 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June 19. 47 to 5 April 19. 48

and that I last saw him alive on 5 April 19. 48

Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to Arteriosclerosis ?

Due to Diabetes Mellitus ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard W. Saunders MD M. D. or other

Address Pontilake md Date signed 6 April 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 338

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

508 S. Division Street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 508 S. Division St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Caldwell F. Holloway

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ada A. Holloway

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 20<sup>th</sup> 18746. (c) If alive, give age 66 years

## 8. AGE:

Years

Months

Days

If less than one day

73427

hrs.

min.

## 9. Birthplace

Parmouth Maryland

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Carpenter

## FATHER

## 12. Name

Joshua James Holloway

## 13. Birthplace

Parmouth Md.

## MOTHER

## 14. Maiden name

Phoebe Ellen Layfield

## 15. Birthplace

Wicomico Co. Md.

## 16. Informant

## Address

Mrs. Ada A. Holloway508 S. Div. St. Salisbury Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 20-1948

(month) (day) (year)

## Cemetery or crematory

Forest Grove Cem.

## Location

Near Parmouth Md.

## 18. Funeral director

Holloway & G. Walter K. Holloway

## Address

Salisbury Maryland

## 19.

4/20/48

19.

48

19.

48

19.

48

19.

48

19.

48

19.

48

19.

48

## 23. SIGNATURE

M. D. or other

Address

Salisbury Md.

Date signed

4/27/48

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 17<sup>th</sup> 1948 at 4:25p

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1946 to 4-17-48and that I last saw him alive on 4-17-48

## Immediate cause of death

Chronic Myocarditis

## Due to

Atherosclerosis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address

Salisbury Md.

Date signed

4/27/48

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

04300

93d

**RECEIVED**

MAY 14 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 336

### 1. PLACE OF DEATH:

County Wicomico  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 years  
Hospital, institution, or street address where death occurred:  
604 State Street  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Wicomico  
City or town Delmar  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 604 State  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Augusta Holloway

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Clyde E. Holloway 6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 17, 1859

8. AGE: Years 88 Months 8 Days 16 If less than one day hrs. min.

9. Birthplace Gantioke - Ind.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Milton Arington

13. Birthplace Gantioke, Ind.

14. Maiden name Betty Stout

15. Birthplace Gantioke, Ind.

16. Informant Mrs. Helen Ryall

Address Delmar Del.

17. Burial, cremation, or removal, Which? Burial Date thereof 4-6-48  
(month) (day) (year)

Cemetery or crematorium St. Olive's

Location Delmar, Delaware

18. Funeral director G. S. Grand Co.

Address Delmar, Delaware

Date rec'd by registrar April 6, 1948 Registrar Harry E. Hudson

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1948 to April 3, 1948

and that I last saw him alive on April 3, 1948

Immediate cause of death Mitral stenosis of car-

diacum & Basilar causing

cardiac failure

Due to cardiac failure

Due to cardiac failure

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Hudson M. D. or other

Address Delmar, Del. Date signed Apr 5/48

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH

shown on:

2411 N. Charles St., Baltimore

FILE No. G 115 MAY 4 - 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 524 Rogers St.  
(If rural, give LOCATION)2. (a) If veteran, name war World War #1

## 3. (a) FULL NAME

Allie Inaley

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color of race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

(No Record)

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

63 62 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Yorkton Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. (Burial, cremation, or removal. Which?)

## Date thereof

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. (Date rec'd by Registrar)

## 20. DATE OF DEATH

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

## and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_

## Immediate cause of death

## Due to

## Due to

## Other conditions

## (Include pregnancy within 3 months of death)

## Major findings of operations

## Date of op.

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

## Date of

## Where did injury occur?

## (City or town)

## (County)

## (State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

## M. D. or other

## Address

## Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948 at 6:40 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10-48 1948 to 7-10 1948

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_

Immediate cause of death Coronary ViscalDue to OcclusionDue to Arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE L. L. Lawry, M.D.

M. D. or other \_\_\_\_\_

Address FreelandDate signed 4-10-48

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04303

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: McCombs  
 County Salisbury  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
R.O. #2  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For new-born infants give residence of mother)  
 State MD County McCombs  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.O. #2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Charles C. Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mamie E. Jones  
 6. (c) If alive, give age 76 years  
 7. Birth date of deceased (mo., day, yr.) Oct. 1 - 1876  
 8. AGE: Years 71 Months 6 Days 11 If less than one day hrs. min.

9. Birthplace Whitton Md. (Wic. Co.)  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name Benjamin Jones

13. Birthplace Pomellville Md.

14. Maiden name Sarah Ennis

15. Birthplace Pomellville Md.

16. Informant Mrs. Mamie E. Jones

Address R.O. #2, Salisbury Md.

17. Burial, cremation, or removal, Which? Buried Date thereof April 15-48  
 (month) (day) (year)

Cemetery or crematory Hickman Cem.

Location Hickman Maryland

18. Funeral director Hallman & G. R. R. Hallman

Address Salisbury Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 48 at 8:50 a.m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from August 4 19 48 to April 12 19 48 and that I last saw him alive on April 11 19 48

Immediate cause of death Cerebral hemorrhage  
Left, hemiplegia right 4 mos

Due to

Due to

Other conditions Aspiration pneumonia 4 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Schler, M.D.  
 Address Salisbury Md. Date signed 4-12-48

19. 4/16 19 48 Registrar W. J. Schler, M.D.

RECEIVED

MAY 14 1948

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 61  
CERTIFICATE OF DEATH

04304

Reg. Dist. No. 333

1. PLACE OF DEATH:  
County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs  
Hospital, institution, or street address where death occurred:  
Ocean City Rd.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Ocean City Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME  
Cecelia Beatrice Kramer

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife George K. Kramer  
7. Birth date of deceased (mo., day, yr.) Sept 6, 1869 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 78 Months 7 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Staten Island, Richmond, N.Y.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Lucas Korn

13. Birthplace Germany

14. Maiden name Margaret Heim

15. Birthplace Germany

16. Informant Mrs. Fred Coyne

Address Ocean City Rd. Salisbury, MD

17. Burial Date thereof April 10, 1948  
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory St. Peters

Location Staten Island, N.Y.

18. Funeral director Hill & Johnson Co.

Address Salisbury, MD.

19. 4/10 19. 48 Registrar Warrick & Johnson  
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/6 19 48 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 48  
4/2 19 48 and that I last saw him alive on 4/6 19 48

Immediate cause of death St. Louis Gayness DURATION 4 dpo

Due to St. Louis Melitile

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John R. Manner M. D. or other 4/6/48

Address Salisbury, MD Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not check age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163 #.

04305

## CERTIFICATE OF DEATH

Reg. Dist. No. 338

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

LANKFORD, Samuel Thomas

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty WicomicoCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Mabel LanfordJune 11, 1880

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 11, 1880

8. AGE:

Years 67Months 10Days 5

If less than one day

hrs. \_\_\_\_\_

min. \_\_\_\_\_

9. Birthplace Accomack County

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Frank Lanford13. Birthplace Accomack County14. Maiden name Sarah Vessels15. Birthplace Accomack County16. Informant A. L. LanfordAddress Hallwood Va.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4. 18, 1948

(month) (day) (year)

Cemetery or crematory Graves CemeteryLocation Hallwood, Va.18. Funeral director Robert ShrevesAddress Parksley, Va.19. 4/23, 1948

(Date rec'd by registrar)

19. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 4819. 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16<sup>th</sup>1948at 5:00 P.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Certificate  
and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 1948

Immediate cause of death

Asphyxia from  
illuminating gas

DURATION

Instant

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide SuicideDate of 4/16/48Where did injury occur? Salisbury

(City or town)

Wicomico

(County)

MD

(State)

Injured at home, farm, industry, public place (where?) at home

Means of injury \_\_\_\_\_

Injured at work? no23. SIGNATURE Charles Fisher MD

M. D. or other

Address Salisbury MDDate signed 4/16/48

RECEIVED

MAY 15 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

552

04306

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Wicomico*  
 County.....  
 City or town *Salisbury*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *6 months*  
 Hospital, institution or street address where death occurred:  
*415 S. Sans St. (Wright Nursing Home)*  
 How long in hospital or institution? *6 mo.*

2. USUAL RESIDENCE (HOME) OF DECEASED: *Wicomico*  
 (For newborn infants, give residence of mother)  
 State *Md.* County.....  
 City or town *Parramontang*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *P.O.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Katie C. Leonard*

3. (b) Social Security Number

4. Sex *female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *single*  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) *May 14-1883*  
 8. AGE: Years *64* Months *11* Days *15* If less than one day..... hrs. min.

9. Birthplace *P.O. Parramontang, Md.*  
 (Town, county, and state)  
 10. Usual occupation *retired*

11. Industry or business

12. Name *Samuel H. Leonard*  
 13. Birthplace *P.O. Parramontang Md*

14. Maiden name *Sarah J. Hartung*  
 15. Birthplace *P.O. Parramontang Md*

16. Informant *Mr. Eric Diller*  
 Address *Mt. Vernon Road Salisbury Md*

17. Burial (Burial, cremation, or removal, Which?) *Burial* Date thereof *May 2-1948*  
 (month) (day) (year)

Cemetery or crematory *Leonard Farm Cem.*  
*P.O. Parramontang Md.*

Location *Hollomay, G. Walter O.R. Hollomay*  
 18. Funeral director *Salisbury Md*

Address

19. *5-12-1948* (Date rec'd by registrar) Registrar *Barrett Johnson*

### MEDICAL CERTIFICATION

20. DATE OF DEATH *April 29th* 19. *48* at *1005 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *admitted* 19. *48* to *certified* 19. *48*  
 and that I last saw him/her alive on *4/29/48*

Immediate cause of death *Cancer of chest wall*  
 Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operations *none*  
 Date of op. ....

Autopsy results *no*  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: *no*  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *Dr. Rademacher*  
 Address *Salisbury Md* Date signed *4/29/48*

DURATION *6 mos.*

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAY 15 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH  
 County Wicomico  
 City or town Salmon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD County Wicomico  
 City or town Salmon  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3.(a) FULL NAME Augustus Newton Lane 3.(b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. Lena Lane

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1890 6.(c) If alive, give age 52 years

8. AGE: Years 58 Months 7 Days 8 If less than one day hrs. min.

9. Birthplace Delmar Sussex, Del.  
 (Town, county, and state)

10. Usual occupation Refiner

11. Industry or business Steam Mill

12. Name William Lane

13. Birthplace Delmar Del.

14. Maiden name Eupenia Henry

15. Birthplace Delmar, Del.

16. Informant Mrs. Lena Lane

Address Salmon Md.

17. Burial (Burial, cremation, or removal. Which) Buried Date thereof 4/15/48  
 (month) (day) (year)

Cemetery or crematory Salmon Cemetery

Location Salmon Md.

18. Funeral director David E. McFarland

Address Salmon Md.

19. 4/16/48 (Date read by registrar) 19 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19 48 at 8:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 19 48 to April 12th 19 48 and that I last saw him alive on April 12th 19 48

Immediate cause of death Central Hemorrhage

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Smith M. D. or Other

Address Salmon Md. Date signed April 13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

MEDICAL CERTIFICATION

RECEIVED  
MAY 11 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH

County McComieCity or town Safety  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1121 Railroad Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComieCity or town Safety  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1121 Railroad Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Maddox Robert Edmund

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Willie J. Maddox

7. Birth date of deceased (mo., day, yr.)

Jan. 18-18736. (c) If alive, give age 70 years

## 8. AGE:

75 Years 2 Months 29 Days hrs. min.

## 9. Birthplace

McComie Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

George Maddox

## FATHER

12. Name Willie J. Maddox13. Birthplace McComie Co. Md.

## MOTHER

14. Maiden name Emily Miller15. Birthplace McComie Co. Md.16. Informant Willie J. MaddoxAddress 1121 Railroad Ave, Safety Md17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof Jul 19/48  
(month) (day) (year)Cemetery or crematorium Parson's Cem.Location Safety Md18. Funeral director Willie J. Maddox & C. Walter R. WilliamsAddress Safety Md.19. 4/19/48 (Date recd by registrar)Barrett S. Johnson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 1948 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and 1948 to 4-17 1948  
and that I last saw him on

Immediate cause of death

Respiratory failureDue to Senility no moreDue to definite diagnosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injury Injured at work?

Signature Robert R. StarrAddress 1121 Railroad Ave, Safety MdDate signed 4/17-48

MARGIN RESERVED FOR BINDING

9:45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAY 14 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. 04309 383

### 1. PLACE OF DEATH:

County Wilcomio

City or town Salesbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Shumaker Loh PO #4

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wilcomio

City or town Salesbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #4 - Johnson Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Mc Cann, Irving

### 3. (b) Social Security Number

4. Sex

m

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Feb 11 - 1932

8. AGE:

16 Years

1 Months

25 Days

If less than one day

.....hrs.

.....min.

9. Birthplace.....

Wilks borough, N.C.

(Town, county, and state)

10. Usual occupation.....

Farm work

11. Industry or business

FATHER

12. Name.....

Walter McCann

13. Birthplace.....

Wilks borough N.C.

MOTHER

14. Maiden name.....

Lela Johnson

15. Birthplace.....

Wilks borough, N.C.

16. Informant.....

(Father) Walter McCann

Address.....

PO #4, Salesbury Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

April 8 - 48

Cemetery or crematorium.....

Wilcomio Min. Park

Location.....

Salesbury Md.

18. Funeral director.....

William C. Walter R. Williams

Address.....

Salesbury Md.

19.

(Date rec'd by registrar)

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

19.

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 6 19 48 at 10:40a

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

4-6

19 48

to

4-6

19 48

and that I last saw him in deceased alive on..... 19.....

Immediate cause of death.....

Respiratory failure

Due to.....

drowning

DURATION

1 hr.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Acc. Date of..... 4/6/48

Where did injury occur?..... Salesbury (City or town) Md. (County) Md. (State)

Injured at home, farm, industry, public place (where?)..... Shumaker's Pond

Means of injury..... Drowning

Injured at work?.....

23. SIGNATURE.....

Robert R. Starr

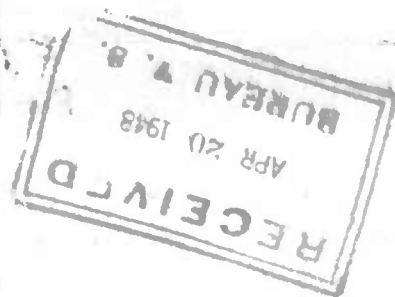
M. D. or.....

Address..... Salesbury Md. Date signed..... 4-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Mann

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04310

## CERTIFICATE OF DEATH

Reg. Dist. No. 533

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 4 days, 10 hrs. 45 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Lake Street Route # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

McKinney, Master Ronald LEE

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb 26, 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

13

If less than one day

4hrs.

min.

9. Birthplace

Salisbury MD  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Apr 9, 48  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 48

Registrar  
Salisbury MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8<sup>th</sup> 19 48 at 12<sup>1/2</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 4 19 48 to April 8 19 48  
and that I last saw him alive on April 7 19 48

Immediate cause of death

myocardial infarction  
24 hours before death

DURATION

within  
7 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John R. Mann

M. D. or other

Address

Salisbury MDDate signed 4/9/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04311

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 yrs  
Hospital, institution, or street address where death occurred:John B. Parsons Home  
How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. John B. Parsons Home  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Clara Meinhardt

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Alfred Meinhardt7. Birth date of deceased (mo., day, yr.) April 16, 1868 6.(c) If alive, give age 78 years8. AGE: Years 80 Months 9 Days 3 If less than one day hrs. min.9. Birthplace Shabow, Germany  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Unknown12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Gutwile PlankAddress Baltimore, Md17. Burial Date thereof April 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chelton HillsLocation Philadelphia, Pa.18. Funeral director The Hill Johnson CoAddress Salisbury, Md19. 4/19/48 19. 48 Registrar Barrie L. Johnson

(Dated by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 48 2:30 a21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/8and that I last saw him alive on 4/16 48Immediate cause of death 1) Diabetes Mellitus DURATION 4 years2) Valvular Heart Disease3) ArteriosclerosisDue to ArteriosclerosisDue to Arteriosclerosis

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Accomac  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
415 Davis St.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Accomac  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 415 Davis St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Melton Samuel F.

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Single

#### 6. (b) Name of husband or wife

6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) June 27-1855

#### 8. AGE:

Years 92 Months 9 Days 20 If less than one day hrs. min.

#### 9. Birthplace

Pocomoke Md.  
(Town, county, and state)

#### 10. Usual occupation

#### 11. Industry or business

#### FATHER

#### 12. Name

Samuel F. Melton

#### 13. Birthplace

P.O. Delmar Md.

#### MOTHER

#### 14. Maiden name

Sarah Eliza White

#### 15. Birthplace

Accomac Co. Md.

#### 16. Informant

My daughter S. Melton

#### Address

229 Newton St. Salisbury Md.

#### (Burial, cremation, or autopsy, Which?)

Buried Date thereof April 19, 1948

#### Cemetery

Parson farm.

#### Location

Salisbury Md.

#### Funeral director

Hollingsworth G. Pelletier R. Hollingsworth

#### Address

Salisbury Md.

#### 19. (Date recd. by registrar)

4/19/48 19 48 Registrar Robert R. Starr

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 48 at SA M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him dead live on April 17 19 48

Immediate cause of death

Semiletic - no more definite diagnosis

Due to semiletic - no more definite diagnosis

Due to semiletic - no more definite diagnosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Starr M. D.

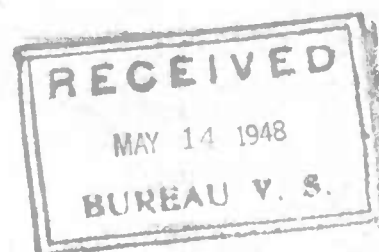
Address Salisbury Md. Date signed 4-17-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04313

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

1. PLACE OF DEATH  
 County Salisbury  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital institution, or street address where death occurred:  
529 S. Dinwiddie St.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County McCombs  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 529 South Dinwiddie St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Charles H. Mitchell

3. (b) Social Security Number

4. Sex Male 5. Color of race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Lucy A. Mitchell  
 6.(c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) July 5-1882  
 8. AGE: Years 65 Months 9 Days 1 If less than one day  
hrs. min.

9. Birthplace Wilmington Delaware  
 (City, town, county, and state)

10. Usual occupation Scholar

11. Industry or business

12. Name Elijah Mitchell

13. Birthplace Burys C. Delaware

14. Maiden name Julia Parsons

15. Birthplace Parsonburg, Md.

16. Informant Mrs. Elsie Murrell

Address 529 S. Dinwiddie St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof April 9-48  
 (month) (day) (year)

Cemetery or crematory Parson's Cem.

Location Salisbury Md.

18. Funeral director William K. Walter R. Hollings

Address Salisbury Md.

19. 4/9/48 1948 Carroll T. Johnson Registrar  
 (Date registered by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6, 1948 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 6, 1948

and that I last saw him alive on April 6, 1948

Immediate cause of death Coronary Heart Failure

Due to myocarditis

Due to myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

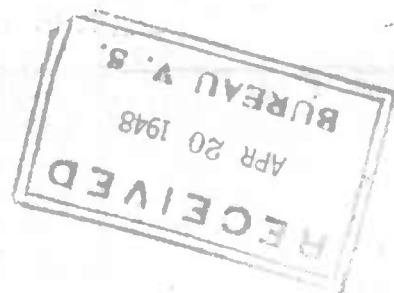
23. SIGNATURE John H. Jeanneret MD  
 M.D. or other

Address 238 Camden Ave Date signed 4-6-48  
Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04314

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County AccomackCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AccomackCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. R 2nd #4  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Morris

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years  
April 22, 19488. AGE: Years Months Days If less than one day  
hrs. 40 min.9. Birthplace Salisbury, Accomack, Maryland  
(town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Morris, Edgar Martin13. Birthplace Salisbury, Md.14. Maiden name Edwards, Ellen Isabelle15. Birthplace Vienna, Md.16. Informant Mr. Edgar MorrisAddress Salisbury, Md.17. Cremation Date thereof April 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Peninsula General HospitalLocation Salisbury, Md.18. Funeral director Peninsula General HospitalAddress Salisbury, Md.19. 4/29, 19 48 Daniel E. Johnson Registrar  
(Date rec'd by registrar) Address Date signed

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 48 at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-22 19 48 to 4-22 19 48  
and that I last saw her alive on 4-22 19 48

Immediate cause of death

Prematurity  
(22 weeks)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

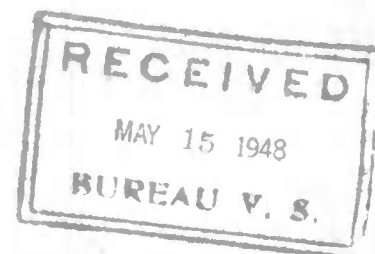
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE LaRademacher MDAddress Salisbury, Md. Date signed 4/22/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 993

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hosp.How long in hospital or institution? 17 days + 20 hrs.

## 3. (a) FULL NAME

Nichols, Le Roy

4. Sex

m

5. Color or race

col

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Louise Nichols

7. Birth date of deceased (mo., day, yr.)

yes 5. (c) If alive, give age Don't know years  
1906

8. AGE:

Years 43Months -Days -

If less than one day

hrs. min.

9. Birthplace

Wicomico County  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Same as above

MOTHER

FATHER

12. Name

Howard Nichols

13. Birthplace

Bridgeville Del

14. Maiden name

Martha Jackson

15. Birthplace

Quantico Md

16. Informant

Howard Nichols

Address

Salisbury Md R.F.D.

17. Burial

Date thereof Apr 21-1948  
(month) (day) (year)

Cemetery or crematory

Quantico Md

Location

Quantico Md

18. Funeral director

James H. Stewart

Address

Salisbury Md

19. Date rec'd by registrar

4/21/48

20. Date of death

4/18/48

21. Signature of physician

Dr. Nichols

Address

Salisbury Md

22. Signature of registrar

Dr. Nichols

Address

Salisbury Md

23. Signature of informant

Dr. Nichols

Address

Salisbury Md

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. Nelson Road  
(If rural, give LOCATION)2. (a) If veteran, name war no

## 3. (b) Social Security Number

Don't know

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1948 at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1906 to April 18 1948and that I last saw him alive on April 18 1948Immediate cause of death Heart attackDue to Heart attackDue to Heart attackOther conditions NoneMajor findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of 4/18/48Where did injury occur? Salisbury Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Salisbury MdMeans of injury Heart attack Injured at work? no23. SIGNATURE Dr. Nichols M. D. or otherAddress Salisbury Md Date signed 4/18/48

RECEIVED

MAY 11 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04316

## CERTIFICATE OF DEATH

Reg. Dist. No. 335

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wright's Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Rufus Payne

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 26. 18608. AGE: Years 87 Months 7 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Worcester Co. Maryland  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

12. Name William W. Payne13. Birthplace Worcester Co. Maryland14. Maiden name Hannah Taylor15. Birthplace Worcester Co. Maryland16. Informant Mrs. Paul EverettAddress Pocomoke City, Maryland17. Burial Date thereof 4/19/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pocomoke CemeteryLocation Pocomoke Cemetery18. Funeral director Howard A. GillAddress Pocomoke City, Maryland19. 4/8/48 19 48 Harriet E. Johnson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-8 19 48 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-1 19 48 to 4-8 19 48and that I last saw him alive on 4-8-48 19 48Immediate cause of death Acute cardiac failure

DURATION

Due to Chronic myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Philip A. Insley M. D. or otherAddress Salisbury, Md Date signed 4-8-48

RECEIVED  
APR 20 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 899

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:  
P. B. Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Earl Rathel

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Anna Rathel

7. Birth date of deceased (mo., day, yr.) November 2, 1893 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 54 Months 5 Days 25 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellersboro, Wicomico, Md.  
 (Town, county, and state)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name John Rathel13. Birthplace Ellersboro, Md.14. Maiden name Ann Williamson15. Birthplace Ellersboro, Md.16. Informant Mrs. Charles PhippinAddress Salisbury, Md.

17. Burial Date thereof 4/29/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salisbury CemeteryLocation Salisbury, Md.18. Funeral director David K. MueselAddress Salisbury, Md.19. 4/29 19. 48 Harriet E. Johnson Registrar

(Date rec'd by registry)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27, 1948 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

death 19. 1948 to 1948and that I last saw him alive on April 27, 1948Immediate cause of death Coronary occlusion

DURATION

4 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; No

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harriet E. Johnson M. D. or otherAddress Salisbury, Md. Date signed 4/29/48

CERTIFICATE OF DEATH

RECEIVED

MAY 15 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

04319

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Waterview  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? lifetime  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Wicomico  
 City or town Waterview  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Vernon Somers

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Winnie W. Somers  
 7. Birth date of deceased (mo., day, yr.) Jan. 22, 1971 8.(c) If alive, give age 72 years  
 8. AGE: Years 77 Months 2 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Nanticoke, Wicomico, Md.  
 (Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

FATHER  
 12. Name George Somers  
 13. Birthplace Nanticoke, Md.  
 14. Maiden name Eliya Messick  
 15. Birthplace Nanticoke, Md.

MOTHER  
 16. Informant Arthur Somers  
 Address Waterview, Md.

17. Burial Date thereof 4/14/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Turners Cemetery  
Nanticoke, Md.  
 Location

18. Funeral director C. S. Messick  
 Address Bivalve, Md.

19. 4/14/48 19. 48 Thasist Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 19. 48 at 12:35 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 30 June 19. 47, to 12 April 19. 48  
 and that I last saw him alive on 12 April 19. 48

Immediate cause of death Pneumo-pneumonia type  
unknown

## DURATION

24 hrs.

Due to extreme sclerotic heart disease 6 mo.  
with heart failure

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Richard H. Saunders MD M. D. or other

Address Ranticoke, Md. Date signed 12 April 48

RECEIVED

APR 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 339

04320

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 10/31/46

Hospital, institution, or street address where death occurred:

Eastern Shore Tb. SanatoriumHow long in hospital or institution? Since 10/31/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WicomicoCity or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 615 Truitt Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

STEELE, Minnie Marie

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife George F. Steele7. Birth date of deceased (mo., day, yr.) August 5, 18886. (c) If alive, give age 50 years8. AGE: Years 59 Months 7 Days 28 If less than one day  
.....hrs. ....min.9. Birthplace Snow Hill, Maryland (Wor. Co.)  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Samuel Dryden13. Birthplace Snow Hill, Md.14. Maiden name Elizabeth Nock15. Birthplace Snow Hill, Md.16. Informant Deceased

## Address

17. Buried Date thereof April 4-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Salisbury, MarylandLocation Yellow & G. Miller & P. Miller18. Funeral director Salisbury, Maryland

Address

19. H/H H.P. Garrison Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 at 8:35 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1947 to April 2, 1948and that I last saw him/her alive on April 2, 1948Immediate cause of death Pulmonary Tuberculosis -  
Far Advanced

## DURATION

4 years  
4 month

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. B. Burke MD

M. D. or other

Address Salisbury, Md. Date signed 4/3/48



Dr. Inley

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04321

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Teagle, William Henry

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hattie Teagle

7. Birth date of

deceased (mo., day, yr.)

Aug 1877

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace

Chome md  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Ethram Teagle

13. Birthplace

Chome md

MOTHER

14. Maiden name

Sara J. Crippen

15. Birthplace

va

16. Informant

Beatrice Teagle

Address

Salisbury md

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

mt nubo cem

Location

mt nubo md

18. Funeral director

Broder M. West

Address

Salisbury md

19.

(Date rec'd by registrar)

8-14-48Barrett L. Johnson  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Wicomico

City or town

West Road Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Route #2

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 30<sup>th</sup>19. 48

at

10<sup>45</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-2419. 48

to

4-3019. 48and that I last saw him alive on 4-30 19. 48

Immediate cause of death

Acute cardiac failure

DURATION

Due to

Chronic arteriosclerotic

Due to

myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Barrett L. Johnson

M. D. or other

Address

Salisbury md

Date signed

8-24-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04322

Reg. Dist. No. 939

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County SussexCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thompson Mr. Glen

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mrs. Sillie Thompson

7. Birth date of deceased (mo., day, yr.)

8/12/1892

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

55814✓ hrs.

min.

9. Birthplace

Delaware  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name Charles E. Thompson

13. Birthplace

Del.

14. Maiden name

Mary E. Windsor

15. Birthplace

Del.

16. Informant

Peninsula Gen. Hosp.

Address

Salisbury, Md.

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

4/29/48

Cemetery or crematory

Odd Fellows

Location

Laurel, Delaware

18. Funeral director

Harvey Williamson

Address

Fredericksburg, Md.19. 4/29/48

(Date rec'd by registrar)

20. Barriett L. Johnson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26, 1948, at 4:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-4-48, 1948, to 4-26-48, 1948and that I last saw him alive on 4-26-48, 1948

Immediate cause of death

Cerebral Edema -

DURATION

12 hrs.

Due to

Delirium Tremens -12 hrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Lu L. Lawry, M.D.

M. D. or other

Address \_\_\_\_\_ Date signed 4-27-48

RECEIVED

MAY 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 04323

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH:</b><br>County... <u>Wicomico</u><br>City or town... <u>Delmar Del. Rural (Double Mills)</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death? <u>29 yrs.</u><br>Hospital, institution, or street address where death occurred:<br>How long in hospital or institution? |  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(For newborn infants give residence of mother)<br>State... <u>MD.</u> County... <u>Wicomico</u><br>City or town... <u>Rural (Double Mills)</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No.<br>(If rural, give LOCATION)<br>2(a) If veteran, name war |  |  |  |
| <b>3. (a) FULL NAME</b> <u>William Clyde Twilley</u>   |  |  |  | <b>3. (b) Social Security Number</b>   |  |  |  |
| <b>4. Sex</b> <u>M.</u> <b>5. Color or race</b> <u>W.</u> <b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>   |  |  |  | <b>MEDICAL CERTIFICATION</b>   |  |  |  |
| <b>6. (b) Name of husband or wife</b> <u>Mrs. Clyde Twilley</u>  |  |  |  | <b>20. DATE OF DEATH</b> <u>April 2</u> 19 <u>48</u> at <u>9:00 A.M.</u>   |  |  |  |
| <b>7. Birth date of deceased (mo., day, yr.)</b> <u>Feb. 3, 1894</u> <b>6. (c) If alive, give age</b> <u>51</u> years  |  |  |  | <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan 1</u> 19 <u>44</u> to <u>Apr 1</u> 19 <u>48</u> and that I last saw him alive on <u>Apr 1</u> 19 <u>48</u>   |  |  |  |
| <b>8. AGE:</b> Years <u>54</u> Months <u>1</u> Days <u>29</u> If less than one day <u>hrs.</u> <u>min.</u>   |  |  |  | <b>Immediate cause of death</b> <u>Cerebral Occlusion</u> <b>DURATION</b> <u>4 hrs.</u>  |  |  |  |
| <b>9. Birthplace</b> <u>Mankla, Wicomico, Md.</u> (Town, county, and state)  |  |  |  | <b>Due to</b> <u>My preclusion</u> <u>4 years</u>  |  |  |  |
| <b>10. Usual occupation</b> <u>Farming</u>   |  |  |  | <b>Due to</b>  |  |  |  |
| <b>11. Industry or business</b>  |  |  |  | <b>Other conditions</b>  |  |  |  |
| <b>12. Name</b> <u>J. Paulsen Twilley</u>  |  |  |  | (Include pregnancy within 3 months of death)   |  |  |  |
| <b>13. Birthplace</b> <u>Mankla, Md.</u>   |  |  |  | <b>Major findings of operations</b>  |  |  |  |
| <b>14. Maiden name</b> <u>Minnie Bacon</u>   |  |  |  | Date of op.  |  |  |  |
| <b>15. Birthplace</b> <u>Mankla, Md.</u>   |  |  |  | <b>Autopsy results</b>   |  |  |  |
| <b>16. Informant</b> <u>Mrs. Clyde Twilley</u>   |  |  |  | <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>   |  |  |  |
| <b>Address</b> <u>Delmar Del. Rtl 2</u>  |  |  |  | <b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>   |  |  |  |
| <b>17. (Burial, cremation, or removal. Which?)</b> <u>Burial</u> <b>Date thereof</b> <u>4/4/48</u> (month) (day) (year)  |  |  |  | Accident, suicide, or homicide. Date of  |  |  |  |
| <b>Cemetery or crematory</b> <u>Mankla Cemetery</u>  |  |  |  | Where did injury occur? (City or town) (County) (State)  |  |  |  |
| <b>Location</b> <u>Mankla, Md.</u>   |  |  |  | Injured at home, farm, industry, public place (where?)   |  |  |  |
| <b>18. Funeral director</b> <u>David C. Messick</u>  |  |  |  | Means of injury Injured at work?   |  |  |  |
| <b>Address</b> <u>Delmar, Md.</u>  |  |  |  | <b>23. SIGNATURE</b> <u>H. S. Kuhlman</u> <b>M. D. or other</b>  |  |  |  |
| <b>19. (Date rec'd by registrar)</b> <u>4/4/48</u> <b>Registrar</b> <u>W. H. Roberson</u>  |  |  |  | Address <u>Delmar, Md.</u> Date signed <u>4/4/48</u>   |  |  |  |



RECEIVED

APR 7 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

04325

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH

County Neonics  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Passwater Nursing Home  
Salisbury Road.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Mulford

City or town Mulford  
(If outside city or town limits, write RURAL and give nearest town)

Street No.                       
(If rural, give LOCATION)

2. (a) If veteran, name war                     

### 3. (a) FULL NAME

Robert I. Warren

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color of face

White

#### 6. (a) Single, married, widowed, or divorced

Widow

#### 6. (b) Name of husband or wife

Acheson Warren

#### 7. Birth date of deceased (mo., day, yr.)

Oct. 7-1859

#### 6. (c) If alive, give age                      years

#### 8. AGE:

Years 88

Months 6

Days 3

less than one day

hrs.                      min.                     

#### 9. Birthplace

Mulford Delaware

#### 10. Usual occupation

Retired

#### 11. Industry or business

David C. Warren

#### 12. Name

Mulford Del.

#### 13. Birthplace

Matilda Ingram

#### 14. Maiden name

Mulford Del.

#### 15. Birthplace

Anthony Purnell

#### 16. Informant

Berlin Md.

#### Address

Bunch

#### 17. (Burial, cremation, or removal, which?)

April 12-48

#### Cemetery or crematorium

Old Fellows Cem.

#### Location

Mulford Delaware

#### 18. Funeral director

William A. Berry Jr.

#### Address

Mulford Delaware

#### 19. (Date rec'd by registrar)

4/12/48

1948

Marrie B. Johnson

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

April 10 1948

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 1948 to April 10 1948

and that I last saw him alive on April 10 1948

#### Immediate cause of death

Uremia

#### DURATION

#### Due to

Chronic Nephritis

#### Due to

Arteriosclerosis & Hypertension

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

..... Date of op. ....

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

#### 23. SIGNATURE

H. P. Grouse M.D.

M. D. or other

Address Salisbury, Md. Date signed 4/10/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 20 1948  
BUREAU V. S.

365

Dr. H.H.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04324

Reg. Dist. No. 339

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Peninsula General Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Pocomoke City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route #1  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

Waters, Walter

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife -  
 7. Birth date of deceased (mo., day, yr.) May 16 - 1940  
 8. AGE: Years 7 Months 10 Days 26 If less than one day - hrs. - min.

9. Birthplace Pocomoke Worcester Md.  
 (Town, county, and state)  
 10. Usual occupation School boy  
 11. Industry or business Edward Waters  
 12. Name Edward Waters  
 13. Birthplace Maryland  
 14. Maiden name Kathleen Wilson  
 15. Birthplace Maryland

16. Informant Edward Waters  
 Address Rural Pocomoke Md.  
 17. Burial Date thereof April 15, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Unionville Cemetery  
 Location Rural Pocomoke Md.  
 18. Funeral director Henry S. Watson  
 Address Pocomoke City, Md.

19. 4/16/48 19 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12<sup>th</sup> 19 48 at 1 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5<sup>th</sup> April 19 48 to 11 April 19 48  
 and that I last saw him alive on 11 April 19 48

Immediate cause of death Tuberculous meningitis DURATION about 2 wks.

Due to -  
 Due to -

Other conditions Primary pulmonary tuberculosis NOT KNOWN  
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. -

Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - Date of -  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury - Injured at work?

23. SIGNATURE Walter M. D.  
 Address Salisbury, Md. Date signed 4/12/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 days  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester  
 City or town Shawell  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Amanda Wells

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Agallie Wells  
 7. Birth date of deceased (mo., day, yr.) Oct. 2, 1881 6.(c) If alive, give age 66 years

8. AGE: Years 66 Months 6 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pittsville, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Agallie Wells

13. Birthplace Md.

14. Maiden name Lucinda Parsons

15. Birthplace Md.

16. Informant Mrs. Agallie Wells

Address Shawell, Md.

17. Burial Date thereof April 13, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Fairlawn

Location Pittsville, Md.

18. Funeral director M. P. Taylor, Statton

Address Silkyville, Md.

19. 4/14/48 Registrar John D. Taylor  
 (Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 11, 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1948 to April 11, 1948 and that I last saw her alive on April 10, 1948

Immediate cause of death \_\_\_\_\_

Cerebral hemorrhage

Due to \_\_\_\_\_

Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Reese A. Taylor M.D. or other \_\_\_\_\_

Address Salisbury, Md. Date signed 4-11-48

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
204 Race street

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State MD. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 204 Race street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) Sept. 28-1897

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 50Months 7Days 0

It less than one day

hrs.

min.

9. Birthplace

Sum. Hill Md.  
(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

Home Painting

MOTHER

12. Name

Zadok Henry Wells

13. Birthplace

Pittsville Md.

14. Maiden name

Viola Jean

15. Birthplace

Pittsville Md.

16. Informant

Address

Mrs. Birdie F. Harris204 Race st. Salisbury Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 1-1948  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registry)

19. 48

Warrant

Register

Address

238 Camden Ave.

Salisbury Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28 19 48 at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2, 19 48 to April 28, 19 48and that I last saw him alive on April 28, 19 48

Immediate cause of death

Pulmonary Tuberculosis 2 years

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

RECEIVED

MAY 15 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 337

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salesbury Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 month  
 Hospital, institution, or street address where death occurred:  
Seneca General Hosp.  
 How long in hospital or institution? 2 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Pocomoke  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

B. Frank Wilson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Rosie B. Wilson

7. Birth date of deceased (mo., day, yr.) June 19, -1875  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 72 Months 9 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Marion Station, Somerset Md.  
 (Town, county, and state)  
Barnes

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name William L. Wilson

13. Birthplace Md.

14. Maiden name Esther A. Green

15. Birthplace Md.

16. Informant Mrs. Rufus Sharnock

Address Pocomoke Md.

17. Burial Date thereof April 3, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Unionton M. P. Cemetery

Location Rural Pocomoke Md.

18. Funeral director Henry S. Sedation

Address Pocomoke Md.

19. 4/3 19 48 Warrant  
 (Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on April 1st 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Carcinoma of tongue 3 years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jack N. Williams

M. D. or other \_\_\_\_\_

Address Salesbury Md. Date signed 4-3-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04328

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)Street No. Collins Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

NO

## 3. (a) FULL NAME

Wootten Mrs. Frances B

## 3. (b) Social Security Number

213-18-4460

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

✓

6.(b) Name of husband or wife

Wootten Mr. William

7. Birth date of deceased (mo., day, yr.)

Oct. 10 - 1913

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

34612

hrs.

min.

9. Birthplace

Salisbury, Wicomico, MD  
(Town, county, and state)

10. Usual occupation

Shoe factory

11. Industry or business

FATHER

12. Name

William H. Bennett

13. Birthplace

Indiana

MOTHER

14. Maiden name

Mary Wootten

15. Birthplace

Maryland

16. Informant

Mr. William M. Wootten

Address

Snow Hill, MD

17. (Burial, cremation, or removal. Which?)

BurialDate thereof April 22, 1948  
(month) (day) (year)

Cemetery or crematory

Methodist

Location

Salisbury, MD

18. Funeral director

Chas. B. Dennis

Address

Snow Hill, MD

19. (Date filed by registrar)

4/22/48 19 48 Registrar John

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 48 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 17, 1948 to April 22, 1948and that I last saw him alive on April 22, 1948

Immediate cause of death

Acute cardiac failure

Due to

chronic myocarditis

Due to

Ruptured peptic ulcer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Ruptured peptic ulcer

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Fluffy A. Lush

M. D. or other

Address

Salisbury, MDDate signed 4/22/48

